Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TOTH ENTERPRISES
4303 VICTORY DR
AUSTIN TX 78704

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-13-1496-01

MFDR Date Received
FEBRUARY 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have faxed this bill to SORM two different times. I have proof that claim was submited [sic] in a timely manner on both occasions. First attempt was on 11/21/12 at 4:20 claim and dictation were faxed and confirmation is attached. Second attempt was on 01/13/12 at 2:34 claim, dictation and proof of timely filing from previous fax was included. Please review as services were rendered in good faith for the benefit of the patient."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office received a medical bill for date of service 9@8/2012 in the amount of $100.00, billing CPT code 99213, an audit found that the bill was not timely filed in pursuant to §Rule 133.20(b). Further review found that the provider has not submitted a request for reconsideration pursuant to Rule §133.250 for the date of service in dispute."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 28, 2012	Office Visit	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §133.250 sets out the procedures for requesting reconsideration of a medical

bill.

4. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
5. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
6. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29 – The time limit for filing has expired.
   - Per Rule 133.20; a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied..." Review of the documentation finds that the requestor faxed the medical bill to the respondents audit company, Forte on November 21, 2012, as noted on the fax confirmation sheet; on January 3, 2013 the requestor faxed the bill to the respondent and submitted it as a "New Bill" as confirmed on the fax confirmation sheet. Therefore, the requestor has not supported that a request for reconsideration for the disputed date of service was made in accordance with 28 Texas Administrative Code §133.250(a), which states in part, "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action."
2. The Division finds that although the bill was submitted to the respondents audit company in a timely manner, the request for reconsideration was not made; therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 23, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.